Ashford and St. Peter's Hospitals NHS Foundation Trust

TRUST BOARD
27th May 2021

AGENDA ITEM	15.3 / 2021	
TITLE OF PAPER	Quality of Care Committee Annual Report (2020/2021)	
Confidential	**No**	
Suitable for public access	**Yes**	
PLEASE DETAIL BELOW THE OTHER SUB-COMMITTEE(S), MEETINGS THIS PAPER HAS BEEN SUBMITTED		
Quality of Care Committee on 20th May 2021		
STRATEGIC OBJECTIVE(S):		
Quality Of Care	✓	
People		
Modern Healthcare		
Digital		
Collaborate	✓	
EXECUTIVE SUMMARY		
	The Quality of Care Committee (QoCC) Annual Report reviews the work of the Committee and demonstrates the extent to which the Committee has met its Terms of Reference, between April 2020 and March 2021. The Board can be assured that it has been appropriately sighted to the key strengths and development areas in the QoCC areas of responsibility and that improvement actions are continuing. QoCC receives appropriate data and information to fulfil its role and has a robust work plan.	
RECOMMENDATION:	To receive for assurance	
SPECIFIC ISSUES CHECKLIST:		
Quality and safety	Y	
Patient impact	Y	
Employee	Y	
Other stakeholder	Y	

Equality & diversity	Y
Finance	N
Legal	Y
Link to Board Assurance Framework Principle Risk	Y
AUTHOR NAME/ROLE	Joanne Finch, Quality & Safety Lead
PRESENTED BY DIRECTOR NAME/ROLE	Andrea Lewis, Chief Nurse
DATE	21st April 2021
BOARD ACTION	To receive for assurance

1.0 INTRODUCTION

In line with best practice, the Quality of Care Committee (QoCC) provides this annual assurance report to Trust Board. Seven meetings were held in 2020/2021, the extra meeting held in April 2020 was for additional assurance, due to the COVID-19 pandemic. All meetings were quorate in accordance with the Terms of Reference (TOR), however the Divisional Directors and some Divisional Exception reporting were stepped down from meetings during the first and second waves of the pandemic.

The membership of the QoCC over the year is set out below along with the maximum number of meetings that could have been attended and actual number attended. Each member (or fully briefed deputy) must attend a minimum of 50% of meetings during the year.

Name	Position	Max	Actual
Mike Baxter	Non-Executive Director (Chair)	3	3
Jane Dale	Non-Executive Director (Chair)	7	7
Marcine Waterman	Non-Executive Director	7	7
Chris Ketley	Non-Executive Director	7	7
Dami Adedayo	Non-Executive Director	3	1
Yvonne Obuaya	Associate Non-Executive Director	3	3
Arun Thiyagarian	Associate Non-Executive Director	3	1
Suzanne Rankin	Chief Executive	4	4
David Fluck	Medical Director	7	5
Andrea Lewis	Chief Nurse	7	7
James Thomas	Chief Operating Officer	7	6

In July 2020 Jane Dale, Non-Executive Director was appointed as Chair of the Committee, when Professor Mike Baxter, Non-Executive Director, stepped down. An annual plan of reports ensures that the appropriate balance of Committee time is given to the Committee's broad scope. Some meeting agendas in 2020/2021 were scaled down reducing the time allotted for Committee meetings and freeing up capacity for members to support the operational pressures the Trust was facing. The below table indicates the reports that were not included on any of the 2020/2021 Agendas, the reason for this and the date the report is next due. This temporary change in QoCC governance at the QoCC (which evolved during the pandemic) provided an opportunity to focus attention and obtain assurance on the quality and safety activity relevant to the evolving situation. Examples include the new IPC model, amendments to the strategy and the introduction of the North Star Objective. A COVID dashboard introduced into the Trust was shared at Board and was reviewed monthly at other meetings, which QoCC members had visibility of.

Report Name	Reason not submitted	2021/2022 Due Date
Patient Experience/ Patient Survey Annual Report	Report not written due to COVID-19 and the redirection of staff to support this.	July 2021
Volunteers Annual Report	Report not written due to COVID-19 and the redirection of staff to support this.	May 2021
Safe Staffing Review	The paper is submitted to the People Committee and was removed from the QoCC annual planner following Committee discussion.	N/A
7DS	The biannual reports were suspended in line with the 'Reducing burden and releasing capacity to manage the COVID-19 pandemic'	N/A

	(March 2020) However, some 7DS data was reported on in the Divisional Exception Reports.	
Quality Report from External Auditor	In March 2020, he Healthcare Quality Improvement Partnership advised that all national clinical audit and confidential enquiries should be suspended.	TBC
CENARG Annual Report	Report suspended in line with the 'Reducing burden and releasing capacity to manage the COVID-19 pandemic' letter to Trusts (March 2020) and the redirection of staff to support the COVID surge.	Sept 2021
CNST	Reporting was suspended in line with the 'Reducing burden and releasing capacity to manage the COVID-19 pandemic' letter to Trusts March 2020. A report is usually provided in the months of January and July. Further progress reports occur as part of the Quality/Divisional reports signed off by delegated authority outside of the QoCC.	July 2020

The QoCC holds 2 key risks to the delivery of the Quality of Care strategic objective identified for the Board Assurance Framework (BAF). The BAF risk descriptions, risk scoring and KPI's are submitted to each QoCC meeting for members to review and agree any proposed changes. The QoCC strategic BAF risks are as follows:

Risk 1.1 - Inability to deliver against key Quality Improvement Priorities and thereby reduce the incidence of repeated and/or avoidable harm to patients from infection, medication errors, episodes of poor care and avoidable mortality, due to insufficient capacity and capability.

Risk 1.2 - Failure to improve and achieve outstanding patient experience, through an inability to harness and optimise learning from patient and family feedback, due to insufficient capacity and capability.

2.0 ASSURANCE REPORTS

Assurance reports have been submitted to QoCC in line with its terms of reference and annual programme. An overview of the developments during the period is provided in this report.

Assurance around COVID -19 inclusive of demand and capacity was provided verbally at the April 2020, May 2020 and July 2020 meetings. In addition, the COVID policy, Infection Prevention Control (IPC) Strategy and IPC BAF were submitted for noting in July 2020. In line with national direction, it was agreed at this meeting that the IPC BAF would be presented at all future meetings (see section 15.0, page 11).

3.0 TRUST STRATEGY AND QUALITY PRIORITIES

Performance against the Quality Priorities was monitored by the QoCC via the bi-monthly Quality Reports to Board. In 2020/2021 the Trust was in the third year of its 5 year strategy (2018 – 2023) and continued to strive towards our transformational vision – *to provide an outstanding experience and best outcome for patients and the team*. Our Quality of Care Strategic Objective to achieve this vision is to '*Create a learning organisation and culture of continuous improvement in order to reduce repeated harms and improve patient experience*'. The quality priorities identified to drive the quality of care transformation agenda focussed on 3 priority learning areas: mortality, errors, and reducing avoidable harm resulting in excellent patient experience monitored via patient feedback.

The Trust's Quality Account and Quality Improvement Priorities for 2020/2021 aligned to the 'Quality of Care' Strategic objective and were submitted to Board for approval in March 2020. The core quality priority areas were: improving medication safety by reducing harm to patients resulting from medications errors and serious incidents; and improving infection prevention and control by reducing the incidence of avoidable harm. Progress against these priorities continues to be reviewed by the QoCC supported by bimonthly Quality Reports and other intelligence as necessary.

An update to the Quality Priorities to reflect COVID-19 was submitted and approved in September 2020.

Due to COVID-19 there was no requirement for the 2019/2020 Quality Account to be published until December 2020 and this was received by the QoCC in November 2020 and agreed by Trust Board for publication.

4.0 PERFORMANCE REPORT

The Chief Operating Officer presented the Performance Reports to the Committee, and these reports should be referred to for the details of the comprehensive performance updates. During the year there was continuous focus on COVID-19 preparations, planning and demand, in line with national standards, and throughout COVID surges this progressed to focus on capacity, activity and elective restart. In January 2021, a redesigned quality focused performance report was presented to the Committee (it was noted that the full performance report is viewed by the Modern Healthcare Committee). The quality focus in the report was welcomed by the Committee.

5.0 SERIOUS INCIDENTS (SI) REPORT

The confidential (closed) SI reports outlined the new SIs arising during the period, compliance with the Duty of Candour, immediate mitigations following an incident, and learning from SIs. Trends in SIs were reviewed and deep dives performed were indicated. A high level summary of claims and Coroners' cases was also provided in these papers. From January 2021 submission of completed Maternity SI Reports were included to meet part of the Essential and Immediate Actions detailed in the Ockenden Report, released in December 2020, with a requirement for this to be reviewed by the Trust Board.

The Annual SI Report was presented to the Committee in November 2020. The delay in submission was due to the revised agendas to support the Trusts operational demands due to COVID-19. The 2019/2020 report summarised patient safety incident reporting, learning and improvement projects completed or underway and the themes and trends identified as a result of patient safety incidents.

6.0 QUALITY REPORT

The Quality Report detailed progress against the Quality Priorities as set for 2020/2021.

6.1 A key quality priority for the Trust has been to develop a safer medicines programme. The aim for 2020/2021 was to reduce medication incidents with any harm to 114 or fewer in the year. The programme delivered sustained improvement and met the 2020/2021 target.

6.2 The key quality priorities for Infection Prevention and Control (IPC) were carried forward from the previous year. The 2020/2021 target was met for Clostridium Difficile infection. The remaining infection control targets for E.coli, Pseudomonas, Klebsiella MRSA and MSSA Bacteraemias were not met.

The increase in blood stream infections (BSI) had also been seen nationally and was to be considered in the context of the extreme demands seen in the COVID-19 pandemic, particularly around the second wave. It was explained to the Committee that this was as a result of a significant increase in ITU patients which peaked to 30, resulting in ITU operating in 3 surge areas as opposed to 1. The redeployment of staff from within the hospital to support surge areas meant staff were working outside of their normal environment caring for high acuity patients with multiple intravenous lines. Although training had been provided for these staff, it was noted that this had been a challenge. BSIs continue to be monitored closely with improvement measures in place.

Due to COVID-19 a new quality priority was approved which was to have zero definitive hospital acquired COVID- 19 cases by March 2021. This target was not met.

6.3 Data collection on Surgical Site Infections (SSI) for submission to Public Health England (PHE), commenced in January 2020 for fractured neck of femur and October 2020 for hip and knee replacements. The data is collected quarterly and publication is another 3 months later, therefore reporting interval are approximately 6 months in arrears. January 2020 data for fractured neck of femur showed that the Trust was an outlier for SSIs when compared nationally, with a Trust rate of 6.5%. However, by September 2020 the data was showing improvement with a rate of 4.3% following implementation of the SSI care bundles. Data on Caesarean section is collected and reported internally and has shown some improvement from the baseline data collected in June 2019. The Quality Report has regularly detailed the work being undertaken to improve all of the Trust's SSI rates and further information detailing this can be viewed in the reports.

6.4 Learning from Deaths summaries were provided via the Quality Report in addition to the quarterly Learning from Deaths Report. See section 10.

6.5 For details on Safety and Learning from errors, please refer to the Annual SI Report submitted to the Committee in November 2021.

6.6 The hospital harms monitored during 2020/2021 included pressure ulcers, falls, the Malnutrition Universal Screening Tool (MUST) and Venous Thromboembolism (VTE). The 2020/2021 targets for reducing harms were not met for hospital acquired category 2 pressure ulcers and hospital acquired category 3 and/or unstageable pressure ulcers. An increase in deep tissue injuries (DTIs)[1] was seen in the Trust and it was explained that DTIs can be a manifestation of COVID-19 related skin damage. A new document highlighting this

[1] Deep Tissue Injuries, although pressure ulcers, are not included in the table as this type of skin damage cannot be attributed a category until the depth of tissue loss is known, a deep tissue injury can fully resolve or can evolve to a category 2 or unstageable pressure ulcer. These are followed up by the Tissue Viability Team until a category can be attributed.

was released by the National Pressure Injury Advisory Panel and the link to this was shared via the Quality Report.

The aim to reduce falls with harm by 10% and the aim for 85% of the MUST to be completed within 48 hours of admission were met.

VTE harms that narrowly missed targets were the percentage of patients admitted to the Trust risk assessed for VTE and first dose of chemical thromboprophylaxis (CTP) administered within 14 hours of admission. The data to confirm the cases of potentially preventable HAT will not be complete until June 2021 and will be reported in the Quality Report.

6.7 The Patient Experience measures saw variability in achieving the monthly targets. With the Patient Experience Team now being fully recruited to it is expected this will improve in future reports. The top 3 Themes in complaints and PALS remained fairly consistent across the year with 'communication', 'delays and/or diagnosis' and 'attitudes of staff', featuring regularly.

Further work was required to improve the recording of compliments and the Volunteer Team have supported this. Regular progress reports were provided on the implementation of Viewpoint, the Real-time Patient Feedback system. This was fully implemented in March 2021 with the SMS text messaging service going live.

Feedback from the Committee was with the implementation of Viewpoint they would like to see more granular data on patient experience represented in the Quality Report. In March 2021 the Quality Report included an outpatient focus, the initial results from the SMS online survey and the FFT responses.

Work to support the Healing Arts Programme had been intermittently paused throughout the year, due to COVID-19.

6.8 From January 2021, the Quality Report included progress against the Provider Board Level Measures detailed in the Ockenden Report. The emerging findings and recommendations from the independent review at the Shrewsbury and Telford Hospital NHS Trust were outlined and Maternity Services submitted the National Assurance Tool to NHSE/I following scrutiny and approval by the Trust Board and Local Maternity System (LMS).

7.0 DIVISIONAL REPORTS

Each of the Clinical Divisions submitted exception reports covering key matters for 5 of the 6 scheduled meetings. In May 2020, July 2020 and January 2021 the Divisions were stepped down to support the COVID response. The work of the Committee continued outside of the meeting with a robust review of the submitted papers and a system of written questions and responses, to address concerns and afford confidence in the assurance provided. It was agreed by Committee members that Divisions would not be required to provide an exception report or attend the March 2021 Committee due to the pressures presented in the COVID-19 second wave.

Some common themes from the Divisional reports during 2020/2021 included overdue incidents, overdue SIs, overdue Code 5 reports, increased pressure ulcers and low appraisal rates. The Patient Safety Team and Divisions worked together to improve the areas of concern and significant improvement was seen in the number of overdue incidents and reducing number of overdue SIs.

Some of the good work reported included the reframing of some services delivery and MDT changed working practices in response to COVID-19, pharmacists supporting primary care, and a new diabetic pathway in WH&P. The COVID response and the service changes over this period were overseen via a robust Trust command and control structure and reported verbally to the Committee as appropriate.

8.0 OTHER EXCEPTION REPORTS

8.1 Berkshire & Surrey Pathology Services (BSPS)

BSPS provide Exception Reports to QoCC in line with the Divisional Reports and were also not required to present/attend all meetings during the COVID -19 pandemic.

BSPS described the Operational support provided to the Trust during the pandemic which included; redistribution of the workforce across the network to meet changing demand, additional transport routes set up to support COVID-19 testing across the network, point of care test (POCT) equipment relocated to support patients within designated COVID-19 critical care areas, increased mortuary capacity and a Phlebotomy appointment booking system being established.

BSPS reported 5 SIs requiring investigation in 2020/2021, 1 was associated with antenatal screening, 2 were in the Cytology Department (booking errors) and 2 were in the Virology Department (resulting of COVID-19 samples and contamination).

Departments on site and across the Network continued to audit against ISO 15189 standards and applicable regulatory requirements. The Virology Department went into voluntary partial UKAS (United Kingdom Accreditation Service) suspension for 3 to 6 months, following BSPS Board approval. The department in conjunction with the BSPS Quality and Governance Department implemented a recovery plan to improve their Quality Management System processes. The Haematology Service provided for all the Surrey sites underwent a UKAS assessment to re-establish the service accreditation. The service reassessment was successful and there were a number of positive comments on the improvements in the quality management system.

8.2 Patient Experience Monitoring Group (PEMG)

PEMG is a quarterly meeting with exception reports to QoCC biannually. Due to COVID-19, the PEMG was held twice; in July 2020 and October 2020. One Exception Report was submitted to QoCC in September 2020, with 4 exceptions identified from the meeting minutes. The quarterly PEMG meetings for 2021/2022 will resume in May 2021.

8.3 Risk Scrutiny Committee

A new risk management structure for the Trust was presented to the May 2019 Audit & Risk Committee. The Risk Scrutiny Committee resumed in July 2020 with refreshed terms of

reference that were approved alongside a new schedule of business. Key changes were as follows:

- Meeting to be held bimonthly
- Chair of the meeting to be a member of the Executive Triumvirate team on a rotational basis
- Quoracy to include at least one representative from each clinical division/corporate service.
- Each division/corporate service to present their risk registers twice a year- allowing for a more structured 'deep dive' approach to the scrutiny of each risk register.

The September 2020 meeting was the first of the new format, which allowed the presenting Divisions more time to discuss and share their registers.

The Risk Scrutiny Committee will present an annual report to the QoCC in September 2021. This will replace the quarterly Exception Reports that were previously submitted.

8.4 Safety and Quality Committee

The Safety and Quality Committee is a bimonthly meeting that was set up in November 2019 to replace the Quality Governance Committee. Due to COVID-19 there were 4 meetings held in 2020/2021 in line with "Reducing burden and releasing capacity to manage the COVID-19 pandemic" letter to Trusts in March 2020. To free up clinician capacity the Divisions were not required to attend all of the meetings. A Safety and Quality Committee Summary Report, including the TOR of the meeting, was submitted to the QoCC in September 2020. Going forward an Annual Report will be submitted to the QoCC in line with the Annual Reporting Schedule.

8.5 Safeguarding Committee

In 2020/2021 the Safeguarding Committee submitted one Exception Report to QoCC outlining non-compliance with safeguarding training.

9.0 CORPORATE QUALITY & REGULATION REPORT

The paper reports on the statutory and regulation requirements including progress against the actions on the Care Quality Commission Action Plan, CQC Engagement, Self-Assessment against the CQC Key lines of Enquiry and on Quality Audits.

In 2020/2021 a new CQC Oversight Committee was established to monitor and drive progress toward closure of the outstanding actions from the CQC action plan. All actions were closed in March 2021, although monitoring, where appropriate, would continue as part of the work of the Oversight Committee.

The CQC routine quarterly engagement with the Trust continued virtually and services reviewed included Infection Prevention and Control, ED and Maternity Services. All engagements were positively received and feedback from the CQC reflected this.

Internal and external audit reports are issued to the Audit & Risk Committee, and the status of those action plans pertaining to QRMNM would be reported by exception to QoCC in the

Regulation Report. Due to COVID-19 internal and many external audits were paused or delayed.

10.0 LEARNING FROM DEATHS

The Committee received quarterly updates on mortality reviews. At the time of writing; in 2020/2021 55% of eligible deaths had an initial review and 51% of Structured Judgement Reviews (SJR) were completed. This figure will be revised upwards in subsequent reporting as cases are reviewed in retrospect. Timely completion of initial review and SJR was affected by the COVID pandemic. There was one death in June 2020 where second stage SJR felt that it may have been possible to discharge the patient sooner, however the patient remained in hospital and contracted COVID-19, which was given as the cause of death. Learning from SJR's is fed back via the divisional governance structure and Trust wide learning events currently delivered virtually. The Medical Examiner role proved vital during the COVID -19 peaks and recruitment was completed to establish the full team. Going forwards, a task and finish group has been convened to work on improving the completion rate of the initial mortality screening forms, complete a business case for funding of SJR reviewers and to finalise the mortality review pathway.

11.0 NOROVIRUS REPORT

The report was submitted in July 2020 and was requested by the Committee following an outbreak of Norovirus with ongoing hospital transmission, which resulted in the closure of some wards, led to the disruption of services and resulted in restricted visiting being implemented.

The report identified that the initial cases were managed with strict infection prevention control measures. However the ongoing spread resulted in more stringent and robust action, which successfully controlled the virus and within 14 days the hospital reported no further cases of Norovirus. The lessons learned included isolation of the index case(s), isolation of symptomatic patients, improved admission assessment, improved communication on transfer/movement of patients and improved hygiene standards.

12.0 ANNUAL CLAIMS REPORT

The Annual Claims Report was presented in July 2020 for the financial year 2019/20. Clinical negligence claims received increased from 60 in 2018/19 to 71 in 2019/20, whilst the number of non-clinical claims increased from 5 in 2018/19 to 10 in 2019/20.

In 2019/20, the annual cost of harm increased across the NHS to approximately £9 billion, of which approximately 60% related to maternity. The Trust NHSR Indemnity Scheme contributions were steadily increasing year on year reflecting the increasing cost of harm.

Four high value claims were concluded where damages of £250,000 or above were paid. The Trust settled or closed 15 clinical claims in 2019/20, two in year, with the rest from claims initiated from 2015-2018. Five non-clinical claims were closed.

Clinical diagnosis, missed or delayed, featured in three of the four high value claims. The total damages for these high value claims were £1.9 million.

The first case involved a patient who sustained an infection following complex knee replacement surgery. Following the knee surgery the patient suffered early delayed wound healing which was not adequately investigated and treated. Subsequent attempts at revision surgery failed and the patient was left with a septic knee which required an above-knee amputation.

The second case involved a patient who was born with spina bifida and congenital hydrocephalus who attended the ED following a collapse/episode of vomiting and abdominal pain. The patient was discharged from the ED without further investigation, but later presented to another in septic shock and coma.

The third case involved a delay in diagnosing and treating coronary artery disease as a result of which the patient suffered a myocardial infarction and died. The patient was referred by his GP to the Rapid Access Chest Clinic following complaints of shortness of breath on minimal exertion. Once he was seen in the Rapid Access Chest Clinic, a diagnosis of musculoskeletal chest pain was made.

A Deep Dive into delayed/missed diagnosis and treatment was reported to Board in 2019 with key learning and actions identified.

The Trust costs for maternity claims accounted for 64.5% of the value of all claims for 15% of the volume. This was similar to the national picture. The Maternity Service continued to progress the NHSI Maternity and Neonatal Safety Improvement Program to drive improved outcomes for patients.

In 2019/20 the Trust performed well compared to the national and regional averages for time taken from notification to resolution of claims. The Trust average was 3.57 years with the national and regional averages being 4.21 and 4.24 years respectively.

13.0 ADULT & CHILD SAFEGUARDING ANNUAL REPORT

The report provided a summary of the key issues and activity in relation to Safeguarding of Children and Adults at the Trust, including provision of care to pregnant women where there was an identified increased safeguarding risk to them or their babies.

The activity of the Children's and Maternity Safeguarding Teams had seen a 26% increase on the previous year with levels similar to those seen in 2017/18, indicating that the 2018/2019 activity levels may have been anomalous. There was a 7% decrease in referral activity in 2019/2020 compared to 2018/19. The number of safeguarding alerts related to alleged harmful care provided at the Trust was 28%, higher than the previous year of 17%. Most of these related to tissue viability management in hospital or issues arising from the discharge process.

Compliance in all safeguarding training requirements was below target.

14.0 DIRECTOR FOR INFECTION PREVENTION AND CONTROL (DIPC) ANNUAL REPORT

The report provided an overview of Infection Prevention and Control (IPC) activities for the Trust in 2019/2020 including incidents and outbreaks, performance against health care trajectories and compliance to the Health and Social Care (H&SC) Act 2008 (Hygiene Code). The year had seen challenges in IPC with the notable outbreak of Norovirus (see section 11.0 above) and the national challenge from the COVID-19 pandemic. The work to reduce gram negative Blood Stream Infection (BSI) and meet the government target both internally and with patients was described. There were two cases of MRSA BSI attributed to the Trust and 27 Clostridium Difficile cases with a trajectory of 28. The majority of cases were deemed unavoidable with no specific learning for the Trust (only 7 cases deemed as avoidable).

The significant response to the COVID-19 pandemic had been challenging due to the pace of change that was required at the start of the pandemic with a high number of admissions between March 2020 and May 2020. The report was submitted to the Committee in July 2020 and therefore did not reflect the second wave of the pandemic.

15.0 INFECTION PREVENTION AND CONTROL BOARD ASSURANCE FRAMEWORK (IPC BAF)

The IPC BAF was published by NHSI/E in May 2020 to support all healthcare providers to effectively self-assess their compliance with Public Health England (PHE) and other COVID-19-related infection prevention and control guidance and to identify risks.

The framework consists of 10 standards to assess against and to identify measures being undertaken, in line with the current guidance. It is to be used to provide evidence as an improvement tool to optimise actions and interventions. It is a source of internal assurance to maintain quality standards for the Director of Infection Prevention and Control, the Medical Director and Chief Nurse as well as the Quality of Care Committee and Trust Board.

The framework was revised by NHSI/E and the new framework shared at the January 2021 QoCC, highlighted the Trusts re-assessment against the 10 standards. Overall there was good compliance with the measures in place. The gaps identified for improvement included promoting the consistent use of lateral flow tests for staff, workplace assessments, reducing repeated patient moves between wards, a review that ensures posters on the correct handwashing process are displayed in all public areas within the Trust, a continuing review of IPC policies and finally the support required to the learning and development department to assist with fit test data upload. In addition, COVID-19 positive cases and HCAI was included in all Quality Reports

17.0 ANNUAL NATIONAL CARDIAC ARREST AUDIT (NCAA)

The Paper was submitted to QoCC in September 2020 and reported that the Trust had an initial survival from cardiac arrest of 49.5%. Survival to discharge was better than the national figure with 20.4% against 18.4% nationally.

The importance of caring for patients in the correct areas was highlighted, as an increase in weekend cardiac arrests was thought to be linked to medical outliers in surgical wards. A new trend of cardiac arrest between 5am and 7am was identified and work was in progress to increase observations during those times. Concerns around the ReSPECT process were also identified with the Trust resuscitating more patients per 1000 beds days than any other

Trust in the country. It was highlighted that patients inappropriately identified for resuscitation did impact on outcomes.

SI ANNUAL REPORT

The paper covered reported Serious Incidents in 2019/2020. Reporting of patient safety incidents had shown a sustained increase year on year with the exception of WH&P, which had remained static since their reporting levels fell in 2016/2017. Trust reporting patterns overall suggested an improved culture with the majority of staff knowing how to report incidents and feeling secure to raise concerns. Staff survey results did however identify the need to strengthen staff confidence that their safety concerns would be addressed and that staff are treated fairly when involved in errors/near misses/misses/incidents.

The Trust continued to report more incidents than the majority of regional peers, although performed less well than some regional peers in the median number of days between incidents occurring and being reported to NRLS. A process change for uploading to NRLS was planned to address this.

The number of SIs saw a reduction of 7 compared to the previous year. SI trends by StEIS category were falls, maternity, treatment delay, diagnostic delay and surgery and the key learning for each of these categories was detailed in the report.

There were 4 Never Events reported in 2019/2020 compared to 1 in 2018/2019. All the events were associated lapses in pre-procedure safety checks. The learning identified an opportunity to expand the mandated Local Safety Standards for Invasive Procedures (LocSSips) to include non-invasive procedures, where safety checking was required.

Duty of Candour compliance remained 100%.

Patient Safety improvement work was detailed in the report and included learning events.

HEALTH AND SAFETY REPORT

Due to the COVID-19 pandemic only one of the two biannual assurance reports was submitted in November 2020.

Training, risk assessments and liaison with Mental Health professionals had been a continuous focus in relation to violence and aggression against staff. Body worn cameras had been a successful technological intervention. The ED had seen some increased reporting of staff abuse, due to anxiety caused by COVID.

Incident numbers had remained stable, although there had been an increase in the number of staff falls reported and a contributory factor to this was thought to be a change in the reporting criteria.

Fire risks remained high profile with work progressing to address fire compartmentation and fire detection systems. Fire mandatory training continued to be a challenge, in addition to maintenance of fire door damage and keeping fire exits free from obstructions.

CONTROLLED DRUGS ACCOUNTABLE OFFICER ANNUAL REPORT

The 2019/2020 report was submitted in November 2020 and reflected the statutory responsibility to monitor controlled drug incidents and flag concerns to national bodies. No concerns had been raised and the number of incidents had been similar to 2018/2019.

Issues identified had been localised to particular wards and a new pharmacy model was implemented to support the ward areas. The overall pattern of incidents involving CDs within the Trust indicated that there were no incidents of suspected misuse, misappropriation, theft or fraud involving CDs. Gaps in compliance standards had been addressed with ward teams and changes implemented as required.

An electronic controlled drug register had been investigated as a solution to recording issues, but there were no products for this being marketed.

HARMS FREE CARE STRATEGY

The report was received for assurance in November 2020 and aligned with the Trust Strategy to reduce hospital associated harms. The report outlined how the strategy would be embedded into the Trust and provided detail and narrative on the Trust targets for reducing harms, how this would be achieved and the monitoring of progress.

OCKENDEN ASSURANCE REPORT

The Maternity Assurance Report was submitted to QoCC in January 2021 following publication of the Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust, the first report following 250 clinical reviews.

Subsequent to the publication of the report NHSI/E requested all Trusts provide assurance of the implementation of the Immediate and Essential Actions (IEAs) contained within the report. The letter also stipulated completion of an assessment tool to be reviewed and approved by Trust Board and signed by the Chief Executive and LMS SRO. The Trust responded within the required deadlines.

The Committee received a copy of the Trusts completed assessment tool. The Committee were informed of the required workforce investment to address some of the IAEs and in particular an additional Obstetric Consultant was required to meet the 7-day standard of twice daily Consultant led ward rounds and uplift in Maternity Provision. It was noted the delivery of staff learning needs was a challenge.

Going forward progress updates were to be included in the Quality Report and completed SI reports (an Ockenden requirement that these are reviewed by the Board) would be included as part of the confidential SI report.

ORGAN DONATION ANNUAL REPORT

The report covered a 2 year period as the 2019/2020 report was not submitted due to the COVID pandemic. In 2019/2020 the Trust were placed as 4th highest Trust in terms of donor numbers in the South East. This had been the busiest year on record at the Trust for organ donation with 15 donors compared to 8 donors in 2018-19 and 8 donors in 2020/2021. The

solid foundations established in the organ donor pathway from donor identification and referral, family approach, consent and donor optimisation had been instrumental in the achievements.

DRAFT QUALITY ACCOUNT PRIORITIES

The Trust wide quality improvement priorities for 2021/2022 were presented to the QoCC in March 2021 and continued to align to the Business Plan, the 'Quality of Care' Strategic Objective, as well as the New Operating Model and Infection Prevention and Control Strategy. The focus of the Quality Priorities on the whole remained unchanged from 2020/2021 although the targets were stretched. The medication safety metric and the patient experience metrics were reviewed following suggestion from the Committee that medication safety could be more ambitious and patient experience would align to the measures set out in the Trust Strategy. A key addition to the priorities related to the introduction of Surrey Safe Care Electronic Records and ensuring the opportunities were maximised to improve patient safety across the Trust and system wide.

BD INFUSION LINE DISRUPTION

In March 2021 a national patient safety alert was issued on disruption to the supply of the BD infusion lines. The Committee were provided with a verbal update on the plans the Trust had implemented, which included a number of practice changes, including carefully prioritising their use based on patient risk assessment and liaison with the National Team managing supply issues; to ensure the Trust received enough ongoing supplies.

DISCHARGE 2 ASSESS AND THE BDO INTERNAL AUDIT

The paper set out the 'Discharge to Assess' (D2A) model and explained the results of the BDO internal audit, which made 6 recommendations. The Audit was commissioned to provide improvement in the Trust internal Discharge Programme. Feedback from the Committee was that the Audit had not provided enough information due to the limited number of patients included and further work would be required to ensure audit designs captured the appropriate level of assurance.

SUMMARY

The Board can be assured that it has been appropriately sighted to the key strengths and development areas in the Committee's areas of responsibility and that improvement actions are continuing. QoCC receives appropriate data and information to fulfil its role and has a robust work plan in place.